

PART ONE

Introduction

This book explores health and healing within the larger picture of changing African societies and cultures. The path of change in health and disease (like that of healing) cannot be understood apart from change in farming, household organization, politics, and migration, among many other elements. When farmers clear the forest, malaria often spreads. When governments build irrigation works, the threat of schistosomiasis usually deepens. If mothers take work time to farm in place of cooking, child malnutrition ordinarily becomes more of a problem. Anyone who wishes to understand the causes of health and illness must therefore inquire into the ecology of forests, the particular way governments build irrigation works, and the complex causes of change in how women organize their workdays. Changing patterns of disease, in Africa as elsewhere in the world, are an integral part of changing society.

Healing, like health, is obviously rooted in the social and cultural order. If we ask about the cultural definition of a living person, then we are addressing profound general questions about morality, about life and death. What separates the living from the dead? How do ancestors come to act in the lives of their descendants? Why are some kinds of social acts (incest, perhaps) seen as dangerous to the health of the perpetrator's relatives? The cultural definition of the individual's place in society, and of the human body and its parts, is inseparable from healing practices. To define dangerous behavior, and to define evil, is to define some causes of illness. As the definition of evil changes, so does the interpretation of illness. To understand change in healing, we must understand what it is that leads people to alter the definition of dangerous social behavior.

It can easily be accepted that health and healing in Africa are shaped by broad social forces. The question is how they are shaped and what is the

process. In answering this question the authors of this book's essays focus on a few main themes.

OPEN QUESTIONS ON THE STUDY OF AFRICAN HEALING

On the subject of healing the late 1970s saw an old paradigm disintegrate under the weight of anomalous information. The old paradigm pictured an African map divided among hundreds of ethnic groups, each with clear boundaries. Each ethnic group was described as having its own set of traditional medical ideas and practices. An ethnic group's healing practices, according to this paradigm, were ordered according to a coherent set of principles defining the different types of forces that cause illness or other misfortune (Horton 1967). These forces might include ancestors, nature spirits, and witches. Healers and diviners did the job of matching the patient's illness with the appropriate niche in the ordered cosmology, thus making a ritual diagnosis.

There were problems with this picture. Ethnographers discovered that in many cases patients did not interpret their own illnesses as caused by supernatural or moral forces, even when the patients recognized a hierarchy of such forces. The nonconforming illnesses had natural causes. Ancestors were not responsible, nor were nature spirits, witches, or sorcerers. The people who suffered these illnesses, or who treated them, said that they "just happened" (Gillies 1976).

The new category of illnesses that "just happened" came into scholarly view as part of a body of new ethnographic information (Chavunduka 1978; Janzen 1978*b*). This reported the world as seen through the eyes of patients. Most previous ethnographies had reported the practices of individual healers, or of categories of healers. Each type of healing had its theory of what causes illness. All practitioner-informants had their own personal interpretive frameworks. The ethnographic study of healing with one healer-informant, or with one category of healers, was likely to lead to a well-ordered description of a hierarchy of illness-causing forces as seen from that particular point of view. What patients see, in Africa as in many other parts of the world, is a diverse, heterogeneous set of options for treatment—options that vary from place to place. In one place a patient, in the course of a single illness, might consult dispensary attendants, Christian or Muslim religious practitioners, medical doctors, specialists in sorcery cures, spirit-possession healers, herbalists, and others. An ethnographer who studies the world from the point of view of patients or their lay attendants is likely to see a much more varied, perhaps chaotic, picture of therapeutic ideas and practices.

As scholarly knowledge of therapies in any one place became more diverse, the map of neat ethnic territories became confused. Each therapy, each type of practitioner and set of ideas, has its own map. It is rare for the bound-

aries of a type of therapy to coincide neatly with the boundaries of an ethnic group, or with those of other therapies in the same general area. Very few of the therapy-distribution maps overlap. In East Africa, for example, Muslims (and Muslim practitioners) are scattered all across the map of the region. The map of Muslims does not match any ethnic map. Nor do maps of spirit-possession practices overlap with ethnic ones. The therapeutic map is no longer divided among bounded ethnic groups. There are actually many maps of therapies within each local region; no two therapy-distribution maps have the same shape.

Anthropologists and historians, when they began to understand that therapies were diverse and not necessarily ethnically based, turned to new sets of questions. There was, for example, a question about the nature of coherence in the midst of therapeutic diversity. It was easy enough to picture the patient's helping relatives choosing among a wide range of alternatives, as though walking through a well-stocked supermarket, taking one therapy or another off the shelf from among an endless array. The problem with this image, however, is that therapies are not neatly laid out on ordered shelves, nor are they contained in cans, or tins, or jars. The interpretation of illness raises questions about the meaning of life and death, and about the causes of misfortune. Naming the condition is central to the therapeutic process, and each name carries profound implications. For a patient to learn in hospital that she has infectious hepatitis can mean that she and her physician share a picture of the nature of infection. More importantly, it can mean that she and the physician see the body as "knowable and treatable in isolation from the human mind and human relations" (Hahn 1982). But then what if the same patient, for the same illness, is also treated for sorcery and then later for Christian spirit possession? Does this mean that the patient and the patient's relatives are buying and then discarding entire theories of the nature of the person—one biomedical, a second focusing on moral relations within the community, and a third based on a Christian view of the supernatural? Or is it true that the patient's relatives hold a single coherent view of the nature of illness, a view related in only limited ways to the views of the various practitioners? Is the lay image of the person's place in the universe of misfortune a coherent and orderly one, or is it diverse, incoherent, and lacking in order?

Scholars of the most recent generation have answered questions like these in very different ways. Gwyn Prins writes in this volume (chap. 13) about persistent "core concepts," a kind of center of gravity for a shared picture of reality. Murray Last, also in this volume (chap. 16), takes the opposite view. He writes that "medicine is being seen not so much as a medical system but as part of the necessary cultural camouflage . . . that enables one to survive, preferably unnoticed, in a diverse society." In his view the laypeople of the area he describes neither know nor want to know about the parts of their medical culture. We cannot describe Last's answer (or Prins's) as the author-

itative one, for the issues will continue to provoke debate. But it is important to see that the patient's eye view of therapeutic diversity raises important questions about the coherence of healing knowledge.

Since the therapeutic map began to lose its clear lines—when ethnomedical boundaries were opened—the course of historical change has needed a new interpretation. It is now impossible to study the history of isolated ethnomedical systems. The history of each set of practitioners and practices, distributed across language or ethnic lines, has its own internal logic. To understand the history of Islamic healing in any one small place the historian or anthropologist needs to understand the broader history of Islam and of healing within it, as Ismail Abdalla (chap. 6, this volume) has shown. Restricting knowledge of Islamic therapies to any one locality will not reveal the most important lines of development. Similarly, one cannot understand the medicine of Christian mission hospitals as strictly local, separate from the wider history of missions and of hospitals. The same point holds for therapies that are not tied to Islam, or to Christianity, or to any world religion. African healers, practicing therapies that originate on the African continent, carry their knowledge from place to place without necessarily halting at ethnic or language boundaries. Many cults of affliction in Zambia, for example, have spread from one part of the country to another. The most popular cults acquire patients and practitioners in a number of districts (Van Binsbergen 1981). Other cults have spread across international borders, originating in Angola and then spreading to Zambia.

The history of healing in Africa has come to resemble the history of religion in a place that experiences broad religious diversity. The history of religion can be written as a story of competing traditions, each with its own ideas and institutions, material interests, and authority structures: the history, for example, of institutionalized Islam or Christianity. Or it can be written as the story of choice within a community. Do men choose one religion and women, another? Do religious divisions emerge between merchants and workers, or between literate people and illiterate ones? For a full account of religion in Dar es Salaam, for example, we would need histories of Islamic brotherhoods (with roots elsewhere in the Islamic world), histories of Catholicism, of evangelical Lutheran Protestantism, and of charismatic versions of Christianity. Each religious tradition must be treated fully on its own, with Dar es Salaam as a mere stopping place. But then we would need to understand local choice—which people in Dar es Salaam have chosen Catholicism, or Islam, and why they have made their own choices.

As in the case of religion, the history of therapy is a history of multiple streams of healing traditions, but with a difference. It is rare to find an individual who will take communion in a Catholic church on one day, begin to fast for Ramadan on the next, and sacrifice to the ancestors on the third. The world religions in particular tend to be exclusive. It is quite usual, by

contrast, for a patient to be treated for sorcery on one day, at a hospital on the second, and for spirit possession on the third. The patterns of choice work themselves out in complex ways within individual illness episodes. Nevertheless, the history of healing is a history of multiple traditions, each one with its own distribution in time and space. The contributions to this volume trace several traditions—the history of Lemba (an Equatorial African cult of affliction), the history of Islamic medicine in Hausaland in northern Nigeria, and the history of Godly Medicine among Anglican missionaries in Tanganyika.

The healing traditions have been forced to provide interpretations of a rapidly changing reality. Conditions of health and disease have changed fundamentally in most parts of Africa over the past century. Each healing tradition (the tradition of cults of affliction, the biomedical one, the Islamic one, and each of the others) has had to find answers to very new questions. When tuberculosis spread to the far-flung rural homes of southern African mine workers, the healing traditions, or rather their practitioners, were forced to respond. Healing conceptions and rituals often seem to be addressing the eternal problems of the human condition—what is the nature of evil, of pollution, of danger, of the relationship between the living and the dead, or between people and spirit. But therapeutic practices are used, in most cases, to treat illness. If illness changes rapidly, then so, too, must healing. In fact, the causal chain forms a double loop here. Healing is rooted in society; as society changes, healing changes with it. Health and disease are rooted in society; as society changes, these also change. Yet changes in healing must respond to changes in health. Neither of the loops can be understood in isolation.

OPEN QUESTIONS ON THE STUDY OF HEALTH AND DISEASE

The varied record of health in Africa over the past century is inseparable from the history of change in control over political institutions and change in the organization of economic production. The continent has seen drastic changes in its basic political and economic framework. In the early years of colonial rule some governments relied on forced labor; in parts of colonial Africa, especially in the eastern and southern parts of the continent, male workers migrated from rural homes, leaving their families behind; in the postcolonial years class differentiation has become more pronounced, with some workers permanently separated from their roots in the countryside. Each different pattern of production and of political control is associated with a particular distribution of health problems. The outcomes are not predictable in any simple way, for they are shaped by changes in the natural environment and by the struggles of workers against their employers and against government, and by farmers against the onerous demands of the state. Nevertheless, important regularities emerge.

Cordell, Gregory, and Piché (chap. 1, this volume) show just how strong the associations are between health and political or economic control. In Ubangi-Shari (later Central African Republic), the years of French rule before World War I were a brutal time. The territory was governed by concessionary companies that forced Africans to collect rubber and other wild products. Many people fled from their homes and farms, leading to a decline in food production. During this period the population dropped, death rates rose, and fertility diminished. The declining likelihood of survival grew directly out of political and economic exploitation. Ubangi-Shari was similar in these respects to King Leopold's Congo (later the Belgian Congo, and now Zaire), in the same period.

As colonial control changed, so, too, did health problems. The 1920s saw a shift to an economy based on cultivation rather than the collection of wild products. The government now compelled farmers to grow cotton, which required intense labor at the same time as the major grain crops—sorghum and millet. The authors hypothesize that hungry-season malnutrition first became a problem in that period. In a general way, the significant point is this. States of health emerge from the basic organization of daily life, as shaped by the entire framework of political and economic control.

One additional example will illustrate the point more fully. It is the story of change in farming after World War II in a single village in the Gambia—Genieri, which became the subject of a detailed series of studies over nearly twenty years (Haswell 1953, 1963, 1975). In this place one of the central agricultural problems, with profound importance for health, was a shortage of food during the most difficult time of the year. This was a time when the new year's rice crop was maturing, making heavy labor demands on women, who did the weeding. It was also a time when the previous year's rice had been exhausted, leaving people hungry, and when some infectious diseases took their greatest toll among infants and young children.

One of the most important ways women, who were the major rice farmers, found hungry-season food was from men's millet farming. Within the large kinship-based compounds, each taking in a number of households, men would join together in cooperative work parties to raise millet. This provided a small proportion of the year's calories, but a proportion available at a desperately important time.

In the postwar period, the men of Genieri began to rapidly expand the amount of time they gave to farming peanuts—a crop that belonged to each man as his personal property and not as the wealth of the compound. A household could live well through the hungry season, without a compound's millet, if it had peanut money for buying food. In some cases, young and vigorous men withdrew from the compounds, leaving millet farming behind, confident that they could live comfortably through the hungry season using cash from their peanut crops. The government tried to help keep up food

production, despite the withdrawal of some men's labor, by building causeways to open up new lands for wet rice. The earlier relatively uniform system of large compounds was replaced by a more diverse pattern: some people still lived in large compounds; others, in relatively unattached households.

This set of changes created a much more diverse social picture than had existed before, with its own profound implications for health. When compounds broke up, there were poor households, some of them woman-centered, which in an earlier period would have been parts of compounds, and which now lost some of their hungry-season food and some health care support. At times the poorer people worked for others to get money for their hungry-season food requirements. Male peanut farmers were affected by fluctuations in the price of peanuts on commodity markets. If they borrowed money for food or farming costs from village moneylenders, their ability to repay depended on unpredictable prices. Some of the most influential men had access to rice at government-controlled prices, or to cooperative credit at rates below those charged by the moneylender. In the early 1970s there were still some large compounds, and these were especially prosperous if they included a successful moneylender, or a man with solid political connections, or in some cases a Koranic scholar with a large following. Some households were very poor, and isolated woman-centered households most probably fared the worst.

This example illustrates the complexity of the relationship between political and economic change and changing health conditions. Initially, the system of farming changed because of decisions by some farming men to grow peanuts. This ended an entire system of growing hungry-season food, and it left some women (and their children) without the nutritional support of compounds. Then the entire system of credit, moneylending, and government control over commercial rice supplies came into play. The precise consequences for health depended on where, in this entire system, the individual was located: in a woman-centered household, or in a large compound that included a moneylender, or in the household of a government official. No one decision or level of control dictated the precise shape of the new system: it emerged from governmental decisions about rice farming, from the way in which the official marketing apparatus passed on to farmers the fluctuations in peanut prices, from the kinship strategies of local men as peanut farmers, from the social organization of Koranic scholars' compounds, from the precise form of governmental control over food supplies, and from the methods local people developed for dealing with the insecurities of world commodity markets.

In spite of the complexity and particularity of these processes, and of others like them around the continent, it is possible to point to a few broad regularities in the way political and economic change has affected states of health in the twentieth century. These include simplification of the food crop

regime, a weakening of kinship-based support mechanisms, and the emergence of profound health consequences growing out of inequalities in the payment of social costs for competing groups of workers.

During the twentieth century the regime of food crops has become consistently simpler. This has come about because of changes in the organization of labor and of marketing. Peasant households use more of their labor for commercial crops or wage labor, reducing the work time for food crop cultivation. The sexual division of labor changes. Some old food crops are abandoned, some preserved, and some new ones chosen. The preferred food crops often make lower demands on soil or labor. This was so in the case of cassava, which was adopted as a replacement for millet and sorghum in Ubangi-Shari (chap. 1, this volume), and which spread widely around the continent. Cassava was not as rich nutritionally as the crops it replaced. In some cases peasants adopt new food crops because they are suitable for marketing, leaving cultivators free to decide after harvest on the proportion of the annual crop to be eaten and the proportion to be sold.

The overall pattern of change in rural society and in its crop regimes leads to an intensification of hungry-season malnutrition (Chambers et al. 1981). It leads also to inequalities in how malnutrition is distributed (Haswell 1975). Rural networks of social support change, leaving some community members unprotected during the hungry season of each year and during famine times. Amartya Sen, in his discussion of entitlements (1981), shows that hunger only rarely emerges from scarcity in the total amount of food a society produces. The people who suffer hunger are those who are not *entitled* to food. These may be whole segments of a national population who (because they are powerless or in political disfavor) are deprived in periods of famine, or they may be vulnerable categories of individuals hidden within local communities.

Another widespread set of regularities in the twentieth century has been in patterns of inequality in the health consequences of the particular form of social organization of economic production. The inequality can be racial, as in the much higher likelihood that black mine workers in South Africa will suffer disabling accidents than will white mine workers. It can be based on class, as in the greater likelihood, in some observations, that children of bureaucrats will receive hospital care than will children of the urban poor. Or the inequalities can emerge within a class, as in the greater likelihood that peasant women without husbands will raise malnourished children than will married peasant women with resident husbands. The evolution of inequalities is the result of the entire process of bargaining and political mobilization involving the state, capital, workers' organizations, and popular political movements. Indeed, it is the result of the contest among all the major players in national (or colonial) political and economic competition.

For example, in South Africa in the late 1970s the children of white work-

ers suffered almost no cases of kwashiorkor, the nutritional disease that was very common among the children of black workers. The two most common blanket explanations are that this state of affairs was the consequence of racism or of capitalism, both of which are in fact defining elements in the political and economic life to South Africa. But then how are we to explain that kwashiorkor existed among white children in the 1930s? Racism and capitalism defined the general social context in both periods; the differences were in the specific nature of the class and ethnic alliances on which the state's power rested. The full story has to do with Afrikaner nationalism, as supported in the 1940s by white workers, white farmers, and other parts of the white electorate. A government came to power in 1948 that (because of the particular pattern of alliances) was devoted to improving the health of poor white children but not of black children (Feierman 1985; Marks and Andersson, chap. 5, this volume; O'Meara 1983).

Similarly, the fact that African children in the city are much more likely to survive to the age of five than are African children in the countryside is the consequence of an extended series of struggles by urban African political movements and trade union organizations. Rent strikes, bus boycotts, and labor actions in the years since World War II have all played a role (Lodge 1983). Manufacturing employers, who invest in workers' skills, have also been more anxious than white farmers or mine managers to see public investment in urban health.

Despite the complexity of the forces in each particular case, there are strong regularities in the distribution of health care and of ill health in twentieth-century Africa. Most colonial health care systems provided care and public health services to white people in the early days, and next to African men at the workplace. In the Ivory Coast in 1952, for example, all eleven major hospitals were found in the rich southern part of the territory, where European enterprise was concentrated (Lasker 1977, 288). Government health services came quite late (after World War II) to African women and children, and to the rural population. Not before this late period, in most colonies, were maternity services introduced (Feierman 1985, 122ff.). Because of the urban bias of colonial medicine, and of the greater political bargaining power of city-dwellers up to the present, urban life expectancy is longer than rural, and urban infant mortality is lower, almost everywhere on the continent. The introduction to part II reviews some of the evidence for this.

The present interpretation, that health can be understood only within the context of political and economic control, leaves us with important open questions. These are questions on which social scientists have not reached clear consensus. The first of these is on the triangular relationships among the politics of class, policies governing the fundamental direction of the economy, and policies governing social issues including health. In the central political battles that change a nation's entire direction, health issues are

usually secondary. The central issues (if they are about more than the access of competing groups to political power) usually concern the shape of the productive economy. Are there to be large farms or small farms? Are factories to get more support than plantations? Will factory owners be national citizens or outsiders? Each decision concerning one of these issues carries implications about a series of other decisions affecting health. The degree of freedom accorded to factory owners usually shapes the quality of regulations on occupational health and on pollution. The question here is, can reformist health policies be successful if they are not part of a broader class politics?

Marks and Andersson's essay in this volume raises that issue. It discusses a failed attempt in 1944 at health reform in South Africa. This was a plan formulated by influential health officials to create a national network of institutions combining health care, health education, public health, and health maintenance. If the attempt had been successful, it would have reduced the striking inequalities still present between the health of whites and blacks, and between the health of Africans in the city and in the countryside.

The initiative failed, but not for lack of intelligence or imagination among planners. The failure grew out of the politics of race, class, and nationality in South Africa. The issue is sometimes interpreted as one of resources; could the South African government at that moment afford to build expensive health institutions? But the turning in the road was really a very different one, involving the entire array of political and economic forces. How could the government at that time respond to both the pressure for city services by urban African squatters and the countervailing pressure by white farmers to keep Africans out of the city and to keep farm wages low? If the government had permitted black people to move freely into the city, and if it had provided a minimum of social and health services there, then many blacks would have left the white-owned farms, where health conditions and wages were appalling. The white farmers demanded that blacks be prohibited from migrating to the cities, and that health and social services in the cities not be so high as to help lure away their labor. Struggles for health are tied to a society's central struggles (Sanders 1985). Marks and Andersson let us see the place of health issues, as interpreted by health professionals, in defining the nation's central conflicts.

A final set of open issues, alongside the relationship between class politics and health policies, is the question of production and reproduction. In the sphere of economic production people work to make goods and to provide economically valued services. The sphere of reproduction encompasses procreation along with the maintenance and preservation of life. Childbirth is included here, along with the intimate care that close relatives give to the sick and to those too old or too weak to work. The assumptions hidden by the definition of these spheres have been challenged by a generation of feminist scholarship. This academic tradition shows that the organization of produc-

tion shapes (and is shaped by) the intimate organization of gender at the domestic level.

Feminist definitions of reproduction are usually broad ones, beyond the reproduction of children through pregnancy and childbirth. Domestic labor, these works argue, is undervalued in capitalist societies because it is not sold. It is tied to a women's sphere, which, even though defined in the first instance by biological reproduction, also takes in the other unpaid work that women do. In the paid labor force women are overrepresented in nurturing and service jobs. Pay for these jobs is low because the work resembles women's unpaid domestic labor (Strobel 1983, 111–112).

The relationship between the two spheres in Africa is important for health. The rural organization of production shapes health by determining the quality of the food supply and the use of the natural environment (and through the environment, the distribution of disease). The organization of reproduction is explicitly devoted to health issues: to childbirth and care of the sick. The interplay between the two, between production and care-giving, is at the heart of health organization. The relationships are so entangled, however, that scholars continue to work on the issues, with no one approach sweeping the field. No orthodoxy has emerged. One problem with the terms is that they make two parallel sets of distinctions, not always found together in reality. "Reproduction" is assumed to have something to do with procreation, or maintenance, or care-giving. It is also seen as related to social ties at an intimate or private level. The definitions leave open the question of how to define women's farm production for private use, or how to define care-giving on a public scale.

Despite difficulties with terminology, production and reproduction point to a cluster of concrete questions on African health. Each question has rich implications; none is to be resolved in any clear way. First, what is the relationship between a society's overall needs for labor, as defined by the holders of power, and the intimate control over pregnancy and childbirth? Colonial authorities in most parts of the continent wanted to increase labor supplies. At the same time, women in some societies were shortening the periods of sexual abstinence after childbirth. They were shortening the space between children, increasing the labor supply (Schoenmaeckers et al. 1981). Were they responding to the demands of authority? What was the mechanism by which public authorities influenced intimate decisions on sexual practice? Was this an accidental relationship between presumed cause and presumed effect? The answers are unknown.

The second set of questions is more widely discussed. When colonial economies use cheap labor or migrant labor, the cost of labor's reproduction is usually paid within the domestic group and the local kinship network (Meillassoux 1975). Neither the state nor employers pay the cost of healthy childbirth, of health care for the young, or of pensions for those who have left the

work force. This is well known and well documented. We do not know very much, however, about the child-rearing and childbirth strategies of different types of households, or about their health effects. In a migrant economy, survival chances differ among children whose mothers are widowed, or divorced, or living far from their natal families, or dead. We do not know exactly how. Nor do we know much about the relationship between women's career patterns and their states of health. With rare exceptions, these questions are in the earliest stages of exploration.

Third, women's relative power at the intimate domestic level is related in unspecified ways to women's participation in public affairs. It is probable that participation in national politics wins for women improvement in private reproductive health. Once again, the core of what we need to understand has to do with the relationship between the most intimate sphere of people's everyday lives and overarching political and economic power.

HEALTH AND MEDICINE IN THE ACTIVE VOICE

Change in disease and in the basic organization of everyday life necessarily leads to change in the measures people take to preserve health, and in healing practices. It is important to recognize that change in the way Africans cope with disease does not merely occur as an automatic reflex, devoid of conscious reflection or creativity. The reality of African healing, when examined closely, is very far from the tired image of an inert, static, un-self-conscious tradition.

Much of what is important about African healing becomes clear only when healers and patients and their relatives are pictured actively creating the particular healing gesture, reshaping healing institutions, and finding the meaning of misfortune. Individuals of course use received language and knowledge, and they act within received institutions, but the language, the knowledge, and the institutions change over time in ways that can be apprehended only if we picture African peasants and city-dwellers as active creators. We need to describe African medicine in the active voice.

The patient's relatives, who try to understand and come to terms with illness, explore the world of misfortune and of therapeutic possibilities as they find it at that moment. In her essay in this volume (chap. 15), Christopher Davis-Roberts reports the illness of a three-year old girl, Malaika ("the Angel," "the Messenger"), who suffered a puzzling series of symptoms—swellings emitting pus, fevers, hives, and other symptoms. Malaika's father, together with the observing anthropologist and others who cared for the child, watched the symptoms unfold through time and tried to understand them despite their ambiguity. The anthropologist contributed tetracycline and penicillin; Malaika's father hunted for a trader who might sell niridazole (used for treatment of schistosomiasis) and (at another time)

tried to understand those relationships among his wife's relatives which might have led Malaika to suffer. The process of creation was a subtle one. It is impossible to say whether any particular therapeutic idea changed as Malaika's treatment unfolded through time. But it is certain also that there was nothing automatic, culturally programmed, or self-evident about the illness, its definition, or the therapy. Those who cared for Malaika acted and by doing so defined themselves in relation to one another, defined the illness, and defined the ultimate causes of misfortune in life as they understood it.

The act of creation in healing is often much more direct and obvious than this, and less subtle, a response to new challenges and opportunities, as when Nigerian healers built businesses for the mass production and transport of herbal remedies. In colonial Northern Rhodesia, as described by Prins, Lozi carefully evaluated the skills of the first European physicians and brought patients who, having been screened by their fellow Lozi, were found to have appropriate conditions. African healers went into business on a large scale selling charms to protect migrant workers from the attack medicines of the many strangers and chance acquaintances they met. The workers, we know, also took measures to protect themselves against the worst dangers of employment. Migrants created communication networks for reporting health conditions—networks that were invisible to the colonial rulers, but which enabled laborers at the mines to avoid employers with the worst records for preserving health.

Also invisible to the authorities were the formal meetings that Zulu diviners began to hold in the city to enforce orthodox practice and to ensure that new generations of diviners would remain true to the core principles of Zulu cosmology (Ngubane 1977). This institution for enforcing the correct practice of tradition was nevertheless active and creative, for it imposed new forms of organization and unity on diviners who were otherwise expected to regulate their occupation along lines laid down by government authorities.

Zulu Christians in separatist churches created entirely new bodies of healing practice and theory. Prophets like Isaiah Shembe found inspiration in their dreams to introduce a new order of religious practice in Zionist churches (Sundkler 1961), using the profoundly evocative symbols of pre-colonial Zulu religion to carry a Christian message. The congregations are communities of suffering and healing. Most new members join because they are ill and hope to find relief from their afflictions (West 1975).

To see African healers and patients as active and creative, altering received knowledge and practice, on a quest for original understanding, is to take a position that is at odds with much of current thinking on social history and the history of ideas. *Annales* historians see continuities over the long term as profoundly important. The seemingly creative acts of individuals are but variations on a continuing theme. Poststructuralists see us all as imprisoned by our language, impotent because we do not understand that our most im-

portant statements are the ones our discourse leaves unsaid and therefore hidden from our own view. Yet the present work insists that African patients and healers think creatively and act with purpose. Their consciousness counts in ways that have always been recognized by scholarship on the creation of European culture, but rarely by scholarship on African culture.

The scattered evidence on the precolonial period reveals a picture of active creation. Janzen's account of consecrated healing knowledge in Equatorial Africa demonstrates that different medicines and different forms of organization dominated in each historical era. Lemba, for example, served in the seventeenth century as a form of sacred knowledge to preserve the health of the king, but then changed in successive generations. Later the kingdoms fragmented; a network of traders tied the region together, using their joint influence in place of royal authority; the merchants served as the senior Lemba priests, using the sacred knowledge as the medicine of government. In the nineteenth century, when venereal diseases threatened fertility, Lemba carried weight as "the government of multiplication and reproduction." The full story, if it were known, would tell of individuals in each generation working to change Lemba's emphasis, applying the sacred knowledge to new domains of experience, and creating new forms of knowledge. The historical records reveals more about the knowledge created than about the creators.

Lemba did not belong to a single ethnic group or linguistic unit. Its senior practitioners stretched across a whole region. They were merchants and judges drawn from a number of places; they formed a web of influential leaders who shared in the sacred medicine of government. It was occupation, not ethnicity, which defined the Lemba priesthood; social variation, not homogeneous "tribal" practice, which determined access to healing knowledge.

THERAPEUTICS IN TOTAL SOCIAL HISTORY

Healing ideas and practices are not a separate domain. They are an integral part of politics, kinship relations, religion, trade, farming, and sexual life. As these evolve, so does healing. It must therefore be understood within the totality of society's social and cultural history. When Africans converted to Christianity, as Ranger shows, missionaries expected that their change of religion would lead them to change their healing practices. The discussion of whether to consult an *mganga* or a physician was not narrowly medical; it revolved around questions of good and evil. Missionaries saw physicians as successors to Christ the Healer. Missionaries treated African choices of therapy as choices of theology. Ranger writes about a missionary (not atypical) who withheld medicine for a child's sores until the mother agreed to cut off all charms. "I told her . . . [the missionary wrote] that I could do nothing till she gave up the medicine of the devil" (1978*b*, 262). This sort of intolerance

was not uncommon. Church authorities, faced with cases of madness that had been attributed to witchcraft, sometimes saw the choice between therapies as one between good and evil. Medicine in this case is not separate from theology. To understand the evolving therapy, one needs to understand the evolution of religious thought.

Medical thought takes on the characteristic ideas of society as a whole. In West Africa in the early colonial years, Curtin shows, public health practice was inextricably linked to the pattern of race relations. The Europeans who planned West Africa's cities assumed that segregation was healthy for whites, that the health of colonialists would be preserved only if they were kept separate from the conquered Africans. The medical justifications for segregation changed with time and place. At times it was plague that seemed to require urban segregation. In some places no Africans were allowed near European quarters, for they were presumed to have malaria parasites in their blood. In other places African servants were allowed, but not other Africans. The medical justifications of the precise health rules were often obscure. In Dakar racial segregation evolved as a plague measure, but continued after the plague threat ended. Africans wealthy enough to live in the European manner built houses alongside the French. Race, culture, and disease merged in a strange complex. Its precise form varied locally. W. J. Simpson of the London School of Hygiene and Tropical Medicine wrote (1914, 9–10, 109):

It has to be recognized that the standards and mode of life of the Asiatic do not ordinarily consort with the European, whilst the customs of the Europeans are at times not acceptable to the Asiatics, and that those of the African unfamiliar with and not adapted to the new conditions of town life will not blend with either. Also that the diseases to which these different races are respectively liable are readily transferable to the European and vice versa, a result especially liable to occur when their dwellings are near each other.

The solution, therefore, Simpson wrote, was to plan separate quarters for Europeans, Asians, and Africans. The racial ideas of the conquerors shaped their understanding of medical problems. Their medical ideas shaped the landscape, and with it the pattern of urban disease. In the case of urban planning as in mission medicine, health practice was incorporated into broader patterns of social and cultural change.

A similar integration is visible in kinship-based therapies. The case of Malaika, described by Davis-Roberts, revolved around the dilemma created when a dead man's relatives blamed his wife for his death. The relatives refused to follow the normal practice of widow inheritance. The disinherited widow then went mad. It was, then, the widow's granddaughter Malaika who suffered illness because of the disturbed relationships. The appropriate therapy for Malaika was one that would treat the complex of relationships.

Widow inheritance, which was at the heart of the family relations affecting